

# SKY ZONE

**Activity # 45023**



**WHO:** GYC & Student Union Members, grades 6-12

**WHERE:** Departs and returns to the Olde Towne Youth Center  
(301 Teachers Way)

**WHEN:** Friday, July 1, 2016  
10:00 am - 1:00pm\*

\*The trip returns at 1:00pm, but the Youth Center will be open until 6pm if participants want to stay

**Cost:** \$20 - Fee does not include lunch.

Lunch will be provided when we return to the Youth Center.

**REQUIRED WAIVER ONLINE**  
[gaithersburgstore.skyzone.com/waiver/](http://gaithersburgstore.skyzone.com/waiver/)

Questions?

Call Maura Dinwiddie or Sara Morgan

301-258-6350 x168

mdinwiddie@gaithersburgmd.gov

The City of Gaithersburg is committed to making reasonable accommodations as required by the Americans with Disabilities Act. Requests must be made at least three weeks prior to the start of the program. Call 301-258-6350 to indicate what accommodations are needed.

## Sky Zone GYC & Student Union - 7/1/16

☐ Check here if new address/phone since last time registered.

Payer's Last Name \_\_\_\_\_ Payer's First Name \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ City Resident ☐ Nonresident ☐

Email \_\_\_\_\_

Participant's Name	Sex M/F	Birthdate M/D/Y	Activity Name	Activity #	Location	Start Date	Grade	School	Fee
			Sky Zone	45023					
			Sky Zone	45023					

**Total \$**

I hereby grant permission for me/my child to attend the activity sponsored by the City of Gaithersburg. I understand that I am responsible for my/my child's insurance in case of injury. Furthermore, I understand that although safety precautions will be observed, the City of Gaithersburg, employees and agents will not be responsible for any personal property lost by me/my child or any injury sustained in the program. I also consent to the City's use of any photographs and/or video tapes made of the program.

\_\_\_\_\_  
Print Parent/Guardian Name

\_\_\_\_\_  
Signature of Parent/Guardian

Does your child have any allergies, medications or conditions that may affect participation in the program? Y ☐ N ☐

Please specify:

Amount Paid \$ \_\_\_\_\_ Cash ☐ Check # \_\_\_\_\_  
Visa/MC# \_\_\_\_\_ Exp. Date \_\_\_\_/\_\_\_\_  
Signature (name on card) \_\_\_\_\_  
Print Name \_\_\_\_\_

**Office Use Only: # 45023**  
Rec'd: \_\_\_\_\_ Initials \_\_\_\_\_  
W P M F Resident: Y N  
Pr: \_\_\_\_\_ Date: \_\_\_\_\_